Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Practice parameters for the treatment of sigmoid diverticulitis.

Bibliographic Source(s)

Feingold D, Steele SR, Lee S, Kaiser A, Boushey R, Buie WD, Rafferty JF. Practice parameters for the treatment of sigmoid diverticulitis. Dis Colon Rectum. 2014 Mar;57(3):284-94. [102 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Rafferty J, Shellito P, Hyman NH, Buie WD, Standards Committee of American Society of Colon and Rectal Surgeons. Practice parameters for sigmoid diverticulitis. Dis Colon Rectum. 2006 Jul;49(7):939-44. [55 references]

Recommendations

Major Recommendations

The levels of evidence and the grades of recommendations (1A-2C) are defined at the end of the "Major Recommendations" field.

Initial Evaluation of Acute Diverticulitis

1. The initial evaluation of a patient with suspected acute diverticulitis should include a problem-specific history and physical examination; a complete blood count, urinalysis, and abdominal radiographs in selected clinical scenarios. Grade of Recommendation: Strong recommendation based on low-quality evidence, 1C.
   Urinalysis and plain abdominal radiographs are helpful in excluding diagnoses in the differential including urinary tract infections, kidney stones, and bowel obstruction. Other diagnoses that can mimic the presentation of acute diverticulitis include irritable bowel syndrome, appendicitis, irritable bowel disease (IBD), ischemic bowel, neoplasia, and gynecologic disorders. In an effort to reduce the misdiagnosis rate among patients with diverticulitis, clinical scoring systems have been proposed that rely on history, physical examination, and blood work.

2. Computed tomography (CT) scan of the abdomen and pelvis is the most appropriate imaging modality in the assessment of suspected diverticulitis. Grade of Recommendation: Strong recommendation based on moderate-quality evidence, 1B.
   In the appropriate setting, multi-slice CT imaging with intravenous and luminal contrast has excellent sensitivity and specificity, reported as high as 98% and 99%. Importantly, cross-sectional imaging can accurately diagnose other disease processes that may mimic the presentation of diverticulitis. The utility of CT imaging goes beyond accurate diagnosis of diverticulitis; the grade of severity on CT correlates with the risk of failure of nonoperative management in the short-term and with long-term complications such as recurrence, the persistence

of symptoms, and the development of colonic stricture and fistula.

3. Ultrasound and magnetic resonance imaging (MRI) can be useful alternatives in the initial evaluation of a patient with suspected acute diverticulitis. Grade of Recommendation: Strong recommendation based on low-quality evidence, 1C.
   Transabdominal, high-resolution ultrasound is an alternative imaging modality that may be useful in patients with relative contraindications to CT scanning (pregnancy, renal insufficiency, and contrast allergy). Ultrasound has a diagnostic accuracy as high as 97%. MRI has sensitivity and specificity as high as 94% and 92%.

Medical Treatment of Acute Diverticulitis

1. Nonoperative treatment typically includes oral or intravenous antibiotics and diet modification. Grade of Recommendation: Strong recommendation based on low-quality evidence, 1C.
   The vast majority of patients diagnosed with diverticulitis who are treated with oral antibiotics are successfully treated as outpatients. Patients with complicated disease (i.e., free perforation, larger abscesses, fistula, or stricture), who cannot tolerate oral hydration, with relevant comorbidities, or who do not have adequate support at home, require hospital admission and, typically, intravenous antibiotics and bowel rest. Antibiotics should cover Gram-negatives and anaerobes. Multidisciplinary, nonoperative management of inpatients with acute diverticulitis is successful in as many as 91% of patients.

2. Image-guided percutaneous drainage is usually the most appropriate treatment for stable patients with large diverticular abscesses. Grade of Recommendation: Strong recommendation based on moderate-quality evidence, 1B.
   Literature supports the concept that percutaneous drainage allows a majority of patients (52% to 74%) to avoid urgent operation and undergo interval elective, 1-stage colectomy. The literature, albeit mostly retrospective, supports the use of percutaneous drainage for accessible, larger abscesses in patients who do not improve with medical therapy. The majority of patients who undergo percutaneous drainage resolve the acute diverticulitis, and a majority of those go on to elective single-stage colectomy. Patients without an adequate radiographic window to permit safe percutaneous drainage may be candidates for operative drainage that is typically accomplished laparoscopically.

Evaluation After Recovery from Acute Diverticulitis

1. After resolution of an episode of acute diverticulitis, the colon should typically be endoscopically evaluated to confirm the diagnosis, if this is a first episode or recent colonoscopy has not been performed. Grade of Recommendation: Strong recommendation based on low-quality evidence, 1C.
   The purpose of the investigation is to exclude diagnoses other than diverticulitis, because patients with simple thickening on imaging may be found to have ischemia, IBD, or neoplasia. Patients with presumed diverticulitis who have not had a recent colon evaluation should undergo colonoscopy, typically within 6 to 8 weeks following resolution of the acute episode (although data supporting this time interval is lacking). The absence of neoplasia on colonoscopy may confirm the diagnosis of diverticulitis suspected on CT. Alternatively, CT colonography may be used in this setting.

Elective Surgery for Acute Diverticulitis

1. The decision to recommend elective sigmoid colectomy after recovery from uncomplicated acute diverticulitis should be individualized. Grade of Recommendation: Strong recommendation based on moderate-quality evidence, 1B.
   Despite previous emphasis on the number of attacks dictating the need for surgery, the literature demonstrates that patients with more than 2 episodes are not at an increased risk for morbidity and mortality in comparison with patients who have had fewer episodes, signifying that diverticulitis is not a progressive disease.

   The decision to recommend elective surgery should be individualized to each patient and should consider the risks of operative therapy, the overall medical condition of the patient, and other factors such as the effects on lifestyle (professional and personal) imposed by recurrent attacks, inability to exclude carcinoma, severity of the attacks, as well as chronic or lingering symptoms that may constitute "smoldering" disease. Potential poor functional outcomes and persistent abdominal symptoms after elective sigmoid colectomy for diverticulitis should be considered as well.

2. Elective colectomy should typically be considered after the patient recovers from an episode of complicated diverticulitis. Grade of Recommendation: Strong recommendation based on moderate-quality evidence, 1B.
   Complicated diverticulitis includes those episodes associated with free perforation, abscess, fistula, obstruction, or stricture. Free perforation resulting in generalized peritonitis requires urgent operative intervention and is reviewed elsewhere (see the section "Emergency Surgery for Acute Diverticulitis," recommendation 1, below). Neither phlegmon nor extraluminal gas alone seen on imaging is considered complicated disease, and these findings should not dictate a specific therapy. Rather, the clinician should consider these findings together with the clinical

scenario, physiologic status, physical examination, and response to ongoing therapy when deciding on operative intervention.

Following successful medical treatment of mesocolic abscesses of ≥5 cm or pelvic abscesses with or without percutaneous drainage, elective colectomy should typically be advised, because retrospective data (albeit with small patient numbers) has shown recurrence rates as high as 40%. In situations where diverticulitis is complicated by stricture or fistula formation, elective or semi-elective resection is generally necessary to provide symptomatic relief.

3. Routine elective resection based on young age (<50 years) is no longer recommended. Grade of Recommendation: Strong recommendation based on low-quality evidence, 1C.
Diverticulitis among young patients has historically been associated with worse clinical outcomes, and young age has therefore been used as an indication for elective surgery following recovery after an acute episode of even uncomplicated diverticulitis. Conflicting data remain regarding the risks for recurrence or complications for younger (age <50 years) versus older patients, although more recent data suggest that age <50 years does not increase the risk for worse clinical outcomes.

Emergency Surgery for Acute Diverticulitis

1. Urgent sigmoid colectomy is required for patients with diffuse peritonitis or for those in whom nonoperative management of acute diverticulitis fails. Grade of Recommendation: Strong recommendation based on moderate-quality evidence, 1B.
Although the majority of patients hospitalized for diverticulitis respond to nonoperative treatment, up to 25% require urgent operative intervention. Patients with multi-quadrant peritonitis or overwhelming infection due to purulent or feculent peritonitis are typically acutely ill or appear toxic and require expedited fluid resuscitation, antibiotic administration, and operation without delay.

   A subset of patients in whom nonoperative management fails do not present as dramatically; rather, these patients simply do not improve clinically and continue with abdominal pain or the inability to tolerate enteral nutrition owing to infection-related ileus or bowel obstruction. Although repeat imaging to evaluate possible abscess formation or to otherwise guide management of antibiotic coverage and parenteral nutrition may be useful, clinical judgment determines the need for definitive surgical treatment.

2. Following resection, the decision to restore bowel continuity must incorporate patient factors, intraoperative factors, and surgeon preference. Grade of Recommendation: Strong recommendation based on low-quality evidence, 1C.
Once the diseased colon is resected, the surgeon may complete the operation by performing a colorectal anastomosis with or without a diverting colostomy or ileostomy, or by constructing an end-colostomy. The clinician must weigh the risks associated with anastomotic failure and of prolonging the operation, while recognizing that end colostomies created under these circumstances are often permanent. Parameters generally favoring proximal diversion include patient and intraoperative factors like hemodynamic instability, acidosis, acute organ failure, and comorbidities such as diabetes mellitus, chronic organ failure, and immunosuppression as well as surgeon preference and experience.

   Primary anastomosis with proximal diversion may be the optimal strategy for selected patients with Hinchey 3 or 4 disease. The decision to create an anastomosis in the setting of peritonitis should be individualized to each patient based on the factors described above. Intraoperative colonic lavage may be used at the discretion of the surgeon to evacuate the column of stool proximal to the anastomosis.

3. In patients with purulent or feculent peritonitis, operative therapy without resection is generally not an appropriate alternative to colectomy. Grade of Recommendation: Strong recommendation based on low-quality evidence, 1C.
Laparoscopic lavage has emerged as a possible surgical alternative for patients in whom medical therapy has failed or who were not candidates for medical therapy to begin with. In theory, lavage is an attractive treatment modality because it avoids much of the morbidity and mortality associated with standard resection-based therapy. The main criticism of lavage is that, by leaving the septic focus in place, patients risk continuing or recurrent infection.

   The safety of lavage for purulent or fecal peritonitis has not been proven or disproven by the published studies to date. European randomized controlled trials are underway that may clarify the role of lavage in the management of patients with diverticulitis. At present, in patients with purulent or fecal peritonitis, lavage is not an appropriate alternative to colectomy.

   Diversion proximal to the inflamed segment without resection is another possible alternative to colectomy in the nonelective setting. Historically, this was the first stage of the 3-stage approach, since abandoned in favor of single or 2-stage procedures. At present, diversion without resection should be reserved for the rare situation where the inflamed operative field is too hostile to permit resection at that time.

Technical Considerations

1. The extent of elective resection should include the entire sigmoid colon with margins of healthy colon and rectum. Grade of

Recommendation: Strong recommendation based on low-quality evidence, 1C.
The distal margin is an important determinant in minimizing the recurrence of diverticulitis and must extend to the proximal rectum to enable a colorectal anastomosis, because a colo-colonic anastomosis significantly increases the risk of recurrence. Patients in whom the proximal rectum is secondarily inflamed may require more extensive rectal resection with a lower rectal anastomosis. The proximal extent of resection in the descending colon is chosen by the absence of thickened, hypertrophic tissue and inflammation. Although it is not necessary to remove all diverticula-bearing colon, care should be taken to avoid incorporating any false diverticula in the proximal side of the anastomosis, because this will increase the risk of leak.

2. When expertise is available, the laparoscopic approach to elective colectomy for diverticulitis is preferred. Grade of Recommendation: Strong recommendation based on high-quality evidence, 1A.
Laparoscopic colectomy by experienced surgeons is safe and results in better short-term outcomes compared with open surgery. Specifically, laparoscopy is associated with decreased operative blood loss, less pain, shorter hospitalization, reduced duration of ileus, reduced complication rates, and improved quality of life. Hand-assisted laparoscopic colectomy may be particularly useful in this setting. The hernia rate in patients who had laparoscopic resection was one-third of the hernia rate in patients who had open or converted operations.

   Laparoscopic sigmoid resection for diverticulitis is technically challenging and requires training and adequate experience. The open approach to diverticulitis should be performed at the discretion of the surgeon as determined by unique patient factors and the individual surgeon's judgment and experience.

3. A leak test of the colorectal anastomosis should be performed during surgery for sigmoid diverticulitis. Grade of Recommendation: Strong recommendation based on low-quality evidence, 1C.
Intraoperative leak testing identifies suboptimal anastomoses that can be repaired, re-created before completing the operation or diverted proximally. Routine testing of colorectal anastomoses reduces the postoperative leak rate.

4. Ureteral stents are used at the discretion of the surgeon. Grade of Recommendation: Weak recommendation based on low-quality evidence, 2C.
Routine use of ureteral stents is not indicated, because ureteral injury during elective colectomy for diverticulitis occurs in well under 1% of cases. The regular use of stents would result in longer operative times and added costs and risks stent-related complications. Stenting may facilitate dissection in selected complicated cases such as patients who are morbidly obese, patients who have been irradiated, patients undergoing reoperation, and patients whose preoperative imaging suggests abnormal anatomy.

5. Oral mechanical bowel preparation is not required; however, the use of oral antibiotics may decrease surgical site infections after elective colon resection. Grade of Recommendation: Strong recommendation based on moderate-quality evidence, 1B.
Oral mechanical bowel preparation before elective, open colon surgery for any indication, studied in randomized fashion and by meta-analysis, does not appear to influence the rates of wound infection or anastomotic failure.

   The use of nonabsorbable oral antibiotics (i.e., erythromycin, neomycin, flagyl, and/or clindamycin) may reduce surgical site complications. *Clostridium difficile* colitis is not increased by the addition of oral antibiotics (1.3% vs 1.8%, $p = 0.58$).

6. Elective colectomy for diverticulitis may be performed by sparing the superior hemorrhoidal artery or according to cancer surgery principles. Grade of Recommendation: Strong recommendation based on low-quality evidence, 1C.
Further randomized study is needed to address this issue. Patients with stricturing disease or who, for whatever reason, have not had neoplasia excluded preoperatively should undergo a cancer-type operation.

Definitions:

The Grading of Recommendations Assessment, Development and Evaluation (GRADE) System–Grading Recommendations[a]

	Description	Benefit vs Risk and Burdens	Methodological Quality of Supporting Evidence	Implications
1A	Strong recommendation, high-quality evidence	Benefits clearly outweigh risk and burdens or vice versa	RCTs without important limitations or overwhelming evidence from observational studies	Strong recommendation, can apply to most patients in most circumstances without reservation
1B	Strong	Benefits clearly outweigh risk	RCTs with important limitations (inconsistent	Strong recommendation, can

	Description	Benefit vs Risk and Burdens	Methodological Quality of Supporting Evidence	Implications
	recommendation, moderate-quality evidence	and burdens or vice versa	results, methodological flaws, indirect or imprecise) or exceptionally strong evidence from observational studies	apply to most patients in most circumstances without reservation
1C	Strong recommendation, low- or very-low-quality evidence	Benefits clearly outweigh risk and burdens or vice versa	Observational studies or case series	Strong recommendation but may change when higher quality evidence becomes available
2A	Weak recommendation, high-quality evidence	Benefits closely balanced with risks and burdens	RCTs without important limitations or overwhelming evidence from observational studies	Weak recommendation, best action may differ depending on circumstances or patients' or societal values
2B	Weak recommendations, moderate-quality evidence	Benefits closely balanced with risks and burdens	RCTs with important limitations (inconsistent results, methodological flaws, indirect or imprecise) or exceptionally strong evidence from observational studies	Weak recommendation, best action may differ depending on circumstances or patients' or societal values
2C	Weak recommendation, low- or very-low-quality evidence	Uncertainty in the estimates of benefits, risks and burden; benefits, risk, and burden may be closely balanced	Observational studies or case series	Very weak recommendations, other alternatives may be equally reasonable

RCT = randomized controlled trial.

[a]Adapted from Guyatt G, Gutterman D, Baumann MH, et al. Grading strength of recommendations and quality of evidence in clinical guidelines: report from an American College of Chest Physicians Task Force. Chest. 2006;129:174–181. Used with permission.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Acute sigmoid diverticulitis

Note: Although diverticulitis may affect any location in the colon, this parameter will focus on left-sided disease.

Guideline Category

Diagnosis

Evaluation

Management

Treatment

Clinical Specialty

Colon and Rectal Surgery

Emergency Medicine

Family Practice

Gastroenterology

Internal Medicine

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Patients

Physician Assistants

Physicians

Guideline Objective(s)

To provide practice parameters for the evaluation and treatment of sigmoid diverticulitis

Target Population

Adults with sigmoid diverticulitis

Interventions and Practices Considered

Evaluation/Diagnosis

1. Problem-specific history and physical examination
2. Complete blood count
3. Urinalysis
4. Abdominal radiographs
5. Computed tomography (CT) imaging of abdomen and pelvis
6. Ultrasound and magnetic resonance imaging (MRI) (as alternative imaging modalities)

Treatment/Management

Nonoperative

1. Oral or intravenous antibiotics
2. Diet modification
3. Image-guided percutaneous drainage
4. Post-recovery endoscopic evaluation (following resolution of a diverticulitis episode)

Surgery

1. Elective surgery
    - Individualized decision for elective surgery
    - Colectomy (laparoscopic approach preferred)
    - Resection (should include the entire sigmoid colon with margins of healthy colon and rectum)
    - Avoidance of elective resection based on young age (<50 years)

2. Emergency surgery
    - Urgent sigmoid colectomy
    - Restoration of bowel continuity after surgery
3. Intraoperative leak testing
4. Ureteral stents (routine use not recommended)
5. Oral antibiotics
6. Sparing of hemorrhoidal artery

Major Outcomes Considered

- Long-term complications
    - Recurrence
    - Persistence of symptoms
    - Development of colonic stricture and fistula
- Sensitivity, specificity, and diagnostic accuracy of testing
- Decreased operative blood loss, less pain, shorter hospitalization, reduced duration of ileus, reduced complication rates, and improved quality of life with laparoscopy

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

These guidelines are built on the last Practice Parameter for the Treatment of Sigmoid Diverticulitis published by the American Society of Colon and Rectal Surgeons. An organized search of MEDLINE, PubMed, EMBASE, and the Cochrane Database of Collected. Reviews was performed through August 2013. Key-word combinations using the mesh terms included "diverticulitis," "diverticulosis," "diverticular," "lavage," "abscess," "fistula," "leak," "complicated," "uncomplicated," "stents," "ureter," "bowel preparation," "Hinchey," "CT," "MRI," "ultrasound," "antibiotics," "resection," "percutaneous drainage," "laparoscopic," and "colectomy." Directed searches of the embedded references from the primary articles were also performed in selected circumstances. Although not intended to be exclusionary, the authors primarily focused on English language manuscripts and studies in adults.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

See the "Rating Scheme for the Strength of the Recommendations" field.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Recommendations were formulated by the primary authors and reviewed by the entire Clinical Practice Guideline Committee. The final grade of recommendation was performed by using the Grades of Recommendation Assessment, Development and Evaluation (GRADE) system (see the "Rating Scheme for the Strength of the Recommendations" field).

Rating Scheme for the Strength of the Recommendations

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Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Not stated

Description of Method of Guideline Validation

Not applicable

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate evaluation and treatment of patients with sigmoid diverticulitis

Potential Harms

- The clinician must weigh the risks associated with anastomotic failure and of prolonging the operation, while recognizing that end-colostomies created under these circumstances are often permanent.
- The decision to recommend elective surgery should be individualized to each patient and should consider the risks of operative therapy. Potential poor functional outcomes and persistent abdominal symptoms after elective sigmoid colectomy for diverticulitis should be considered as well.
- Although it is not necessary to remove all diverticula-bearing colon, care should be taken to avoid incorporating any false diverticula in the proximal side of the anastomosis, because this will increase the risk of leak.

Contraindications

Contraindications

Relative contraindications to computed tomography (CT) scanning include pregnancy, renal insufficiency, and contrast allergy.

Qualifying Statements

Qualifying Statements

- These guidelines are inclusive, and not prescriptive. Their purpose is to provide information on which decisions can be made, rather than dictate a specific form of treatment. These guidelines are intended for the use of all practitioners, health care workers, and patients who desire information about the management of the conditions addressed by the topics covered in these guidelines.
- It should be recognized that these guidelines should not be deemed inclusive of all proper methods of care or exclusive of methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding the propriety of any specific procedure must be made by the physician in light of all the circumstances presented by the individual patient.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Identifying Information and Availability

Bibliographic Source(s)

Feingold D, Steele SR, Lee S, Kaiser A, Boushey R, Buie WD, Rafferty JF. Practice parameters for the treatment of sigmoid diverticulitis. Dis Colon Rectum. 2014 Mar;57(3):284-94. [102 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2000 (revised 2014 Mar)

Guideline Developer(s)

American Society of Colon and Rectal Surgeons - Medical Specialty Society

Source(s) of Funding

American Society of Colon and Rectal Surgeons

Guideline Committee

Clinical Practice Guideline Task Force of the American Society of Colon and Rectal Surgeons

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Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Rafferty J, Shellito P, Hyman NH, Buie WD, Standards Committee of American Society of Colon and Rectal Surgeons. Practice parameters for sigmoid diverticulitis. Dis Colon Rectum. 2006 Jul;49(7):939-44. [55 references]

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the American Society of Colon and Rectal Surgeons (ASCRS) Web site .

Print copies: Available from ASCRS, 85 W. Algonquin Road, Suite 550, Arlington Heights, Illinois 60005.

Availability of Companion Documents

None available

Patient Resources

The following are available:

- Diverticular disease. Patient brochure. Arlington Heights (IL): American Society of Colon and Rectal Surgeons; 2012. Electronic copies: Available from the American Society of Colon and Rectal Surgeons (ASCRS) Web site .
- Diverticular disease. Patient education video. Arlington Heights (IL): American Society of Colon and Rectal Surgeons; 2013 Aug. Electronic copies: Available from the ASCRS Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This summary was completed by ECRI on February 12, 2001. The information was verified by the guideline developer as May 4, 2001. This NGC summary was updated by ECRI Institute on May 31, 2007 and April 23, 2014.

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